



US009192490B2

(12) **United States Patent**  
**Hepworth et al.**

(10) **Patent No.:** **US 9,192,490 B2**  
(45) **Date of Patent:** **Nov. 24, 2015**

(54) **DEVICE FOR MAINTAINING PATENT  
PARANASAL SINUS OSTIA**

(71) Applicant: **Audubon Technologies, LLC**, Denver,  
CO (US)

(72) Inventors: **Edward J. Hepworth**, Denver, CO  
(US); **Corey B. Kashiwa**, Denver, CO  
(US); **Steven P. Tyrrell**, Erie, CO (US)

(73) Assignee: **Audubon Technologies, LLC**, Denver,  
CO (US)

(\*) Notice: Subject to any disclaimer, the term of this  
patent is extended or adjusted under 35  
U.S.C. 154(b) by 0 days.

(21) Appl. No.: **14/496,763**

(22) Filed: **Sep. 25, 2014**

(65) **Prior Publication Data**

US 2015/0081032 A1 Mar. 19, 2015

#### **Related U.S. Application Data**

(62) Division of application No. 13/009,456, filed on Jan.  
19, 2011, now abandoned, which is a division of  
application No. 12/181,416, filed on Jul. 29, 2008, now  
Pat. No. 8,303,640.

(60) Provisional application No. 61/050,827, filed on May  
6, 2008, provisional application No. 60/952,606, filed  
on Jul. 30, 2007.

(51) **Int. Cl.**  
**A61F 11/00** (2006.01)  
**A61F 2/82** (2013.01)  
(Continued)

(52) **U.S. Cl.**  
CPC . **A61F 2/82** (2013.01); **A61F 2/186** (2013.01);  
**A61F 2/958** (2013.01);

(Continued)

(58) **Field of Classification Search**

CPC ..... A61F 2/82; A61F 2/958; A61F 2/186;  
A61F 2250/0004; A61F 2/945; A61F  
2250/0012; A61F 2210/0004; A61F  
2250/0078; A61F 2250/0039; A61F 2250/004;  
A61C 13/225; A61C 8/0092  
USPC ..... 606/191, 194, 196, 199, 108; 623/1.11,  
623/1.13, 1.15, 1.19, 10  
See application file for complete search history.

(56) **References Cited**

#### **U.S. PATENT DOCUMENTS**

4,327,736 A 5/1982 Inoue  
4,603,152 A 7/1986 Laurin et al.

(Continued)

#### **FOREIGN PATENT DOCUMENTS**

EP 0761251 3/1997  
WO 2005/122953 A2 12/2005  
WO 2009/018248 A1 2/2009

#### **OTHER PUBLICATIONS**

Freeman, SB, Blom ED: Frontal Sinus Stents. Laryngoscope 2000,  
110:1179-82.

(Continued)

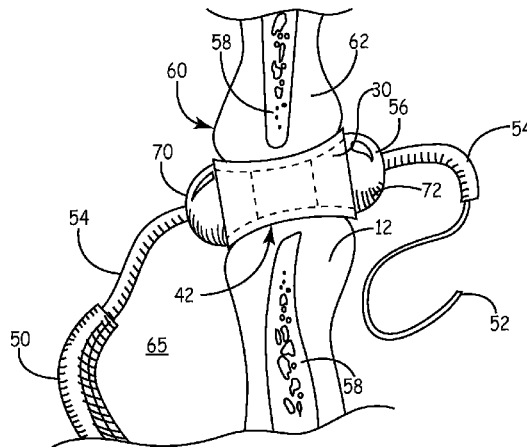
*Primary Examiner* — Amy R Weisberg

(74) *Attorney, Agent, or Firm* — James A. Sheridan;  
Sheridan Law, LLC

(57) **ABSTRACT**

There is disclosed a method for maintaining a patent paranasal sinus ostium. In an embodiment, the method includes delivering a tubular element in an insertion state to the sinus ostium. The tubular element includes a proximal end, a distal end, and a center region between the proximal end and distal end. The method includes expanding the tubular element from the insertion state to a deployment state when located in the sinus ostium. In the deployment state, the center region confronts the sinus ostium with an outward radial force.

**12 Claims, 9 Drawing Sheets**



- (51) **Int. Cl.**  
**A61F 2/18** (2006.01)  
**A61F 2/958** (2013.01)
- (52) **U.S. Cl.**  
CPC **A61F 2210/0004** (2013.01); **A61F 2250/0004**  
(2013.01); **A61F 2250/0039** (2013.01); **A61F**  
**2250/0078** (2013.01)
- (56) **References Cited**
- U.S. PATENT DOCUMENTS
- |              |      |         |                    |            |
|--------------|------|---------|--------------------|------------|
| 4,650,488    | A    | 3/1987  | Bays et al.        |            |
| 4,863,444    | A    | 9/1989  | Blomer             |            |
| 4,964,850    | A    | 10/1990 | Bouton et al.      |            |
| 5,129,889    | A    | 7/1992  | Hahn et al.        |            |
| 5,234,457    | A    | 8/1993  | Andersen           |            |
| 5,246,455    | A    | 9/1993  | Shikani            |            |
| 5,313,967    | A    | 5/1994  | Lieber et al.      |            |
| 5,443,495    | A *  | 8/1995  | Buscemi et al.     | 623/1.21   |
| 5,601,594    | A    | 2/1997  | Best               |            |
| 5,670,161    | A *  | 9/1997  | Healy et al.       | 623/1.42   |
| 5,693,065    | A    | 12/1997 | Rains, III         |            |
| 5,746,745    | A    | 5/1998  | Abele et al.       |            |
| 5,755,708    | A    | 5/1998  | Segal              |            |
| 5,891,133    | A    | 4/1999  | Murphy-Chutorian   |            |
| 5,968,088    | A    | 10/1999 | Hansen et al.      |            |
| 5,976,152    | A    | 11/1999 | Regan et al.       |            |
| 6,120,534    | A *  | 9/2000  | Ruiz               | 623/1.19   |
| 6,273,910    | B1 * | 8/2001  | Limon              | 623/1.15   |
| 6,348,067    | B1   | 2/2002  | Baum et al.        |            |
| 6,767,346    | B2   | 7/2004  | Damasco et al.     |            |
| 6,796,960    | B2 * | 9/2004  | Cioanta et al.     | 604/103.01 |
| 6,878,758    | B2   | 4/2005  | Martin et al.      |            |
| 6,994,689    | B1   | 2/2006  | Zadno-Azizi et al. |            |
| 7,235,097    | B2   | 6/2007  | Calisse et al.     |            |
| 7,241,308    | B2   | 7/2007  | Andreas et al.     |            |
| 7,361,168    | B2   | 4/2008  | Makower et al.     |            |
| 7,654,997    | B2   | 2/2010  | Makower et al.     |            |
| 7,682,371    | B2   | 3/2010  | Spurchase          |            |
| 7,771,482    | B1 * | 8/2010  | Karmon             | 623/17.17  |
| 7,794,494    | B2   | 9/2010  | Sahatjian et al.   |            |
| 8,034,046    | B2 * | 10/2011 | Eidenschink        | 604/531    |
| 8,348,969    | B2 * | 1/2013  | Keith et al.       | 606/199    |
| 8,349,969    | B2 * | 1/2013  | Park et al.        | 525/404    |
| 8,834,468    | B2 * | 9/2014  | Justin             | 606/62     |
| 2002/0123765 | A1   | 9/2002  | Sepetka et al.     |            |
| 2003/0069539 | A1   | 4/2003  | Gandhi et al.      |            |
| 2003/0105469 | A1 * | 6/2003  | Karmon             | 606/92     |
| 2003/0135268 | A1   | 7/2003  | Desai              |            |
| 2004/0010304 | A1   | 1/2004  | Weber et al.       |            |
| 2004/0034405 | A1 * | 2/2004  | Dickson            | 623/1.11   |
| 2004/0064150 | A1 * | 4/2004  | Becker             | 606/196    |
| 2004/0116958 | A1 * | 6/2004  | Gopferich et al.   | 606/199    |
| 2004/0122110 | A1   | 6/2004  | MacCabee et al.    |            |
| 2004/0249343 | A1 * | 12/2004 | Cioanta            | 604/113    |
| 2005/0015140 | A1 * | 1/2005  | deBeer             | 623/1.21   |
| 2005/0216074 | A1 * | 9/2005  | Sahatjian et al.   | 623/1.11   |
| 2005/0234453 | A1   | 10/2005 | Shaolian           |            |
| 2005/0240147 | A1 * | 10/2005 | Makower et al.     | 604/96.01  |
| 2005/0288551 | A1   | 12/2005 | Callister et al.   |            |
| 2006/0004323 | A1 * | 1/2006  | Chang et al.       | 604/28     |
| 2006/0095066 | A1 * | 5/2006  | Chang et al.       | 606/199    |
| 2006/0210605 | A1 * | 9/2006  | Chang et al.       | 424/434    |
| 2006/0286145 | A1   | 12/2006 | Horan et al.       |            |
| 2007/0005094 | A1 * | 1/2007  | Eaton et al.       | 606/199    |
| 2007/0014830 | A1 * | 1/2007  | Tijmsa et al.      | 424/426    |
| 2007/0027525 | A1   | 2/2007  | Ben-Muvhar         |            |
| 2007/0156251 | A1 * | 7/2007  | Karmon             | 623/23.61  |
| 2007/0179426 | A1 * | 8/2007  | Selden             | 604/8      |
| 2007/0250105 | A1 * | 10/2007 | Ressemann et al.   | 606/196    |
| 2007/0293936 | A1 * | 12/2007 | Dobak              | 623/1.13   |
| 2008/0015540 | A1 * | 1/2008  | Muni et al.        | 604/500    |
| 2008/0077240 | A1 * | 3/2008  | Saidi              | 623/10     |
| 2009/0036968 | A1 * | 2/2009  | Hepworth et al.    | 623/1.11   |
| 2009/0177221 | A1   | 7/2009  | Kramann            |            |
| 2009/0198216 | A1 * | 8/2009  | Muni et al.        | 604/514    |
| 2010/0036473 | A1 * | 2/2010  | Roth               | 623/1.11   |
| 2010/0100170 | A1 * | 4/2010  | Tan et al.         |            |
| 2011/0021986 | A1   | 1/2011  | Zamboni            |            |
| 2014/0243975 | A1 * | 8/2014  | Saidi et al.       | 623/10     |
- OTHER PUBLICATIONS
- International Search Report and Written Opinion for PCT/US2008/071419 mailed Dec. 22, 2008, 13 pp.
- Benoit, CM, et al. "Combined External and Endoscopic Frontal Sinusotomy with Stent Placement: a Retrospective Review", Laryngoscope 2001, 111:1246-1249.
- Bolger, WE, et al. "Catheter-Based Dialation of the Sinus Ostia: Initial Safety and Feasibility Analysis in a Cadaver Model", Am J Rhinol. 2006 May-Jun.; 20(3):290-4.
- Brown, CL, et al. "Safety and Feasibility of Balloon Catheter Dilation of Paranasal Sinus Ostia: a Preliminary Investigation", Ann Otol Rhinol Laryngol. Apr. 2006; 115(4):293-; discussion 300-1.
- Ponsart, Biodegradation of [3H]Poly(-caprolactone) in the Presence of Active Sludge Extracts. Biomacromolecules. 2001; 2(2). 373-7.
- Rains, III, MD, "Frontal Sinus Stenting", Otolaryngol Clin North Am. 2001 Feb.; 34(1):101-10.
- Weber, et al., "The Success of 6-Month Stenting in Endonasal Frontal Sinus Surgery", Ear Nose Throat J 2000, 79:930-932, 934, 937-938.
- Supplementary Partial European Search Report for EP 08 79 6750 dated Jul. 13, 2015, 3 pp.
- \* cited by examiner

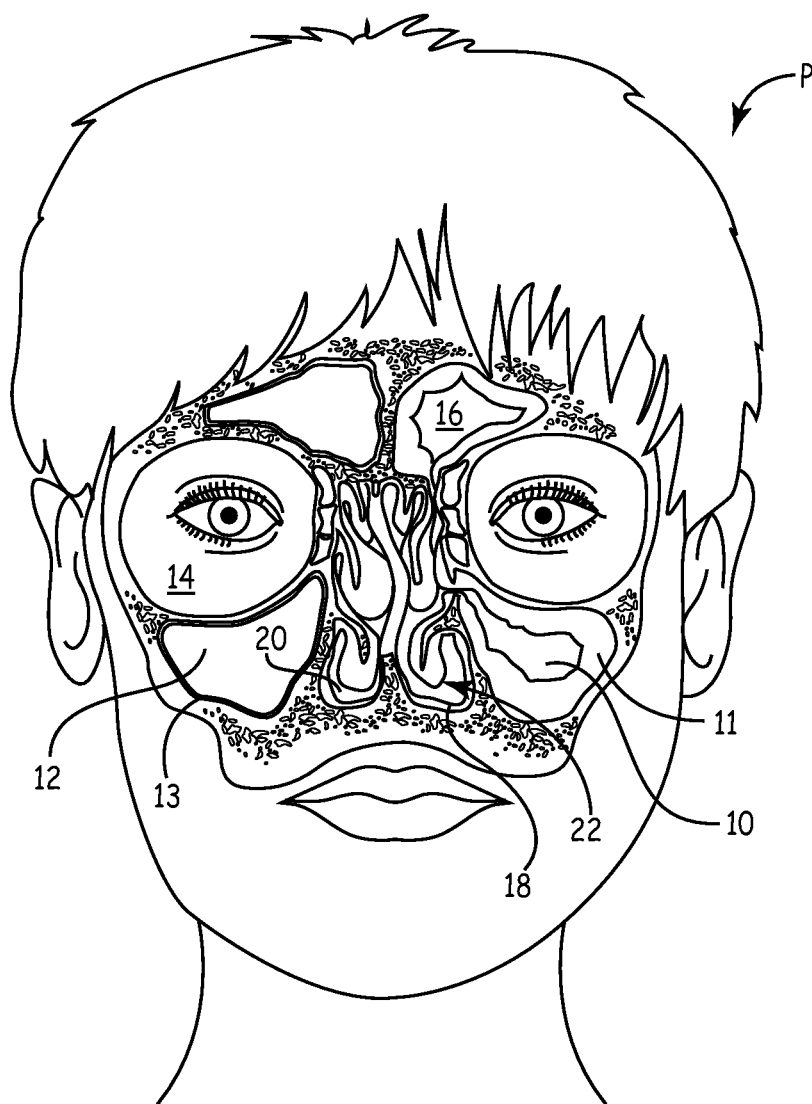


FIG. 1

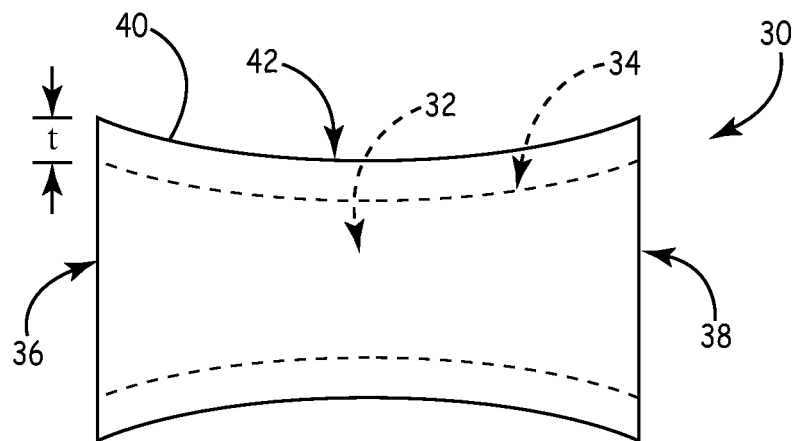


FIG. 2

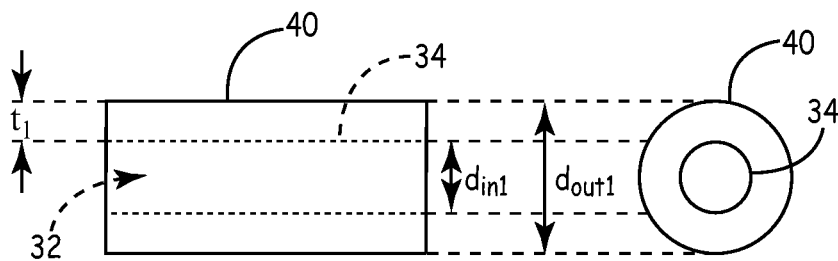


FIG. 6A

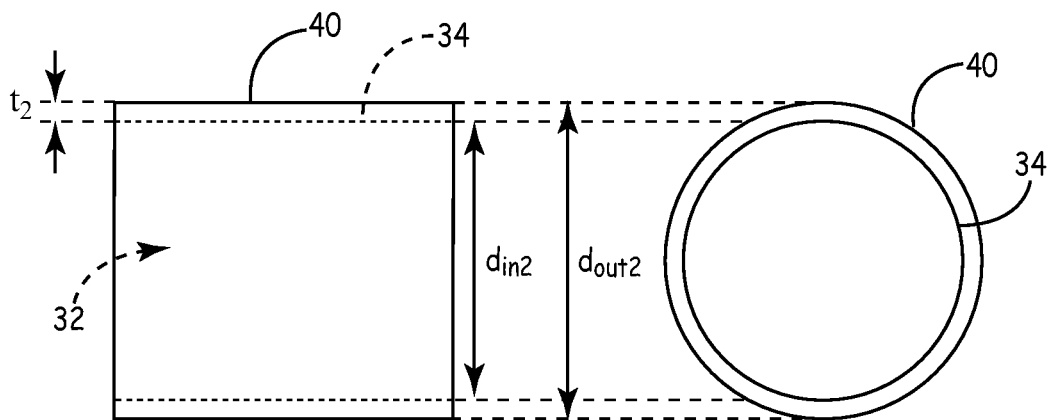


FIG. 6B

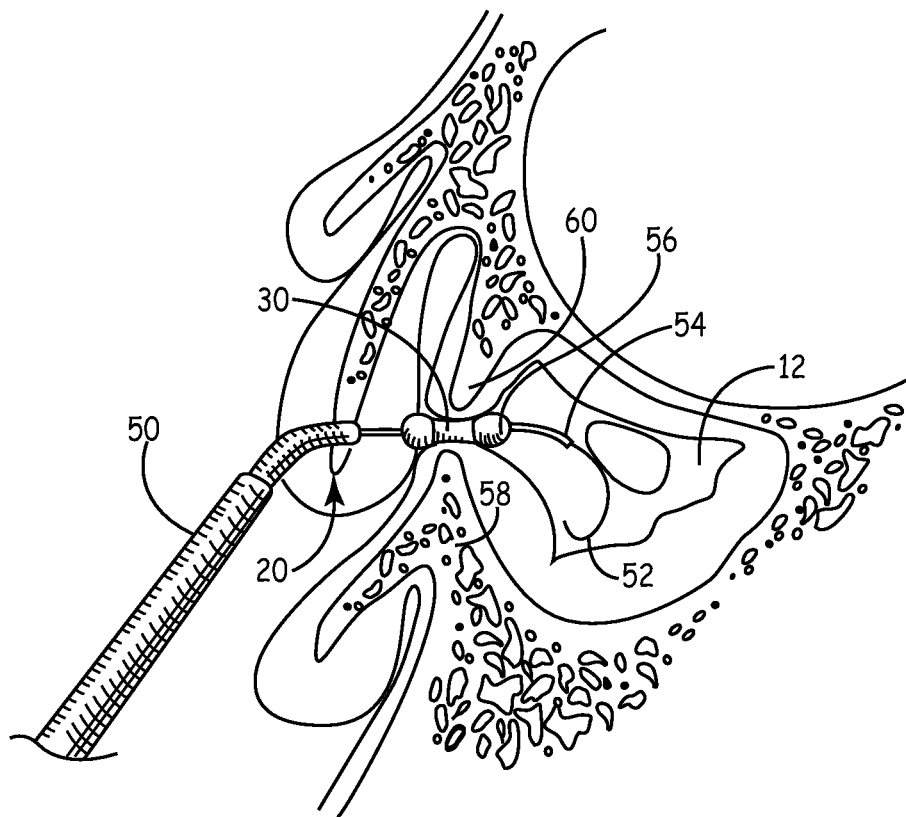


FIG. 3

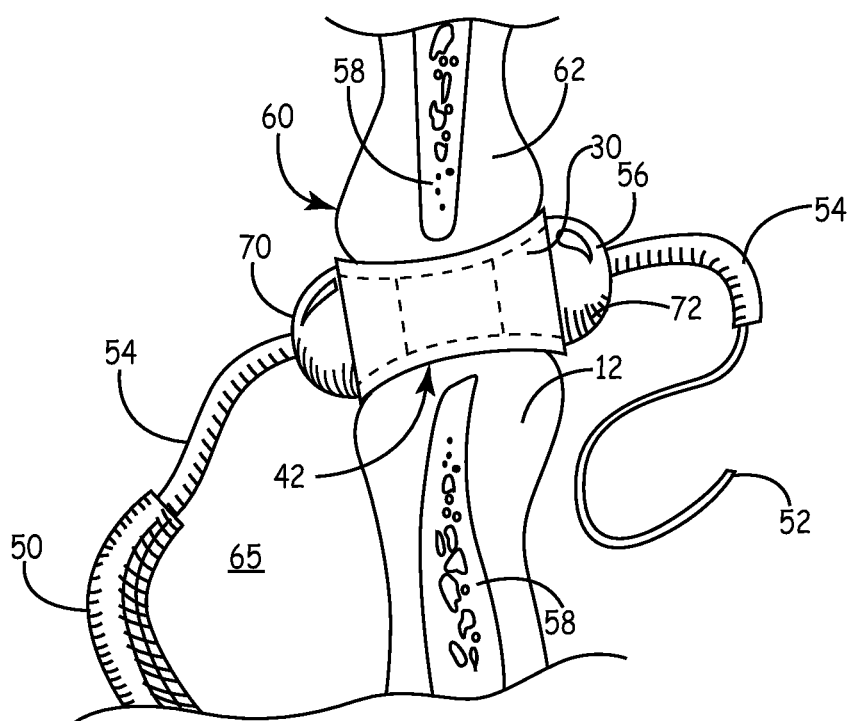


FIG. 4

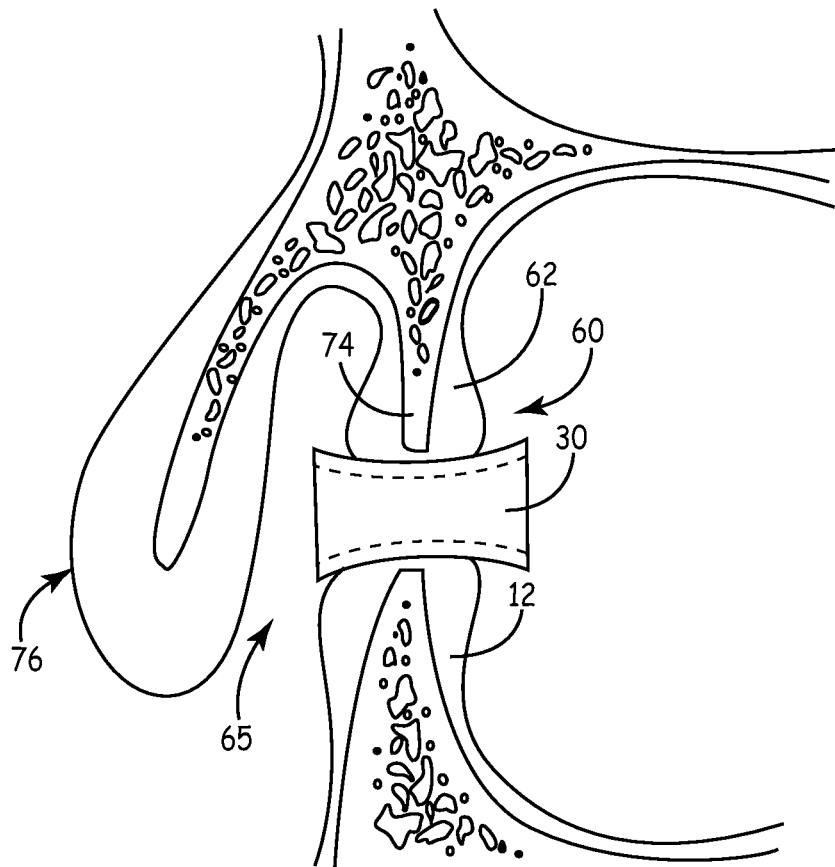
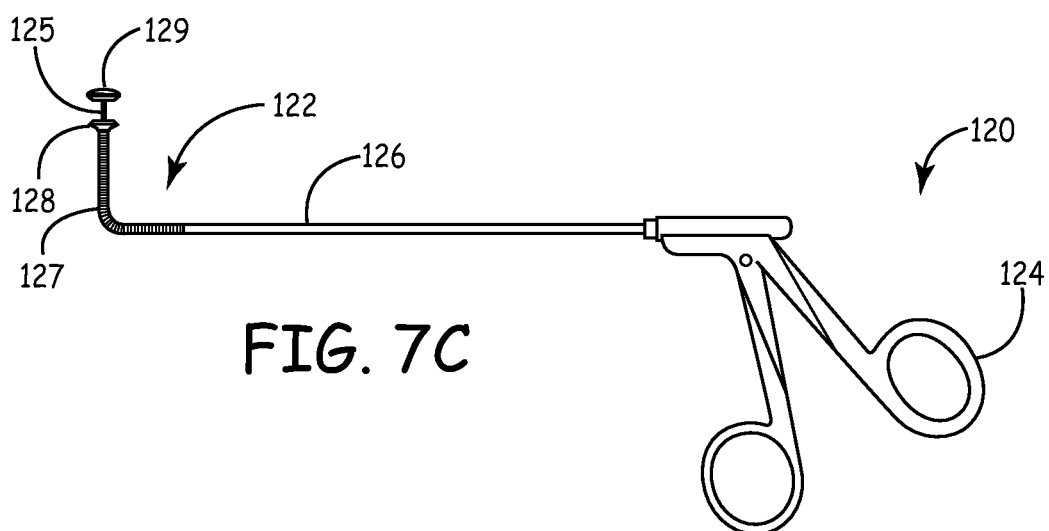
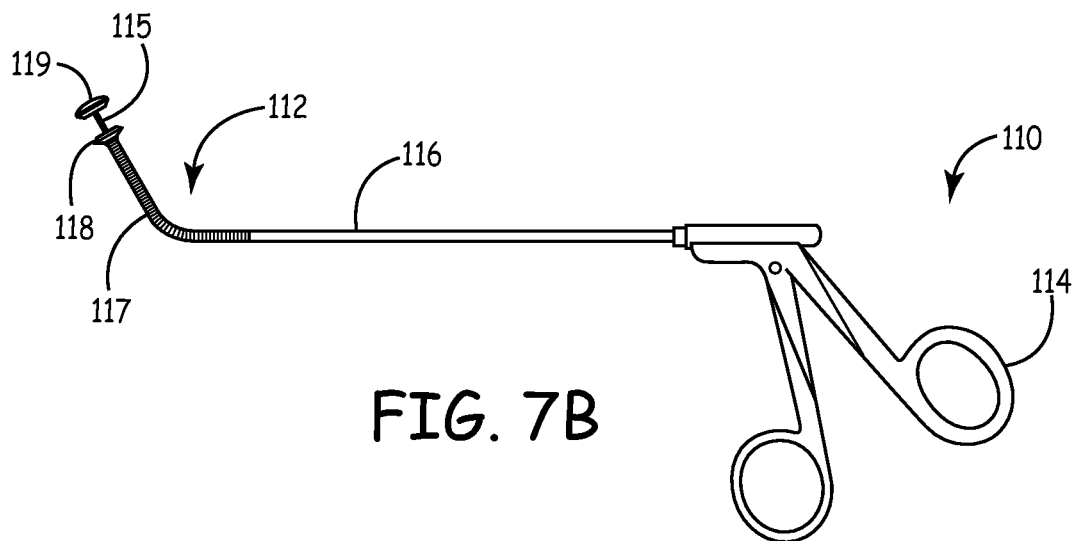
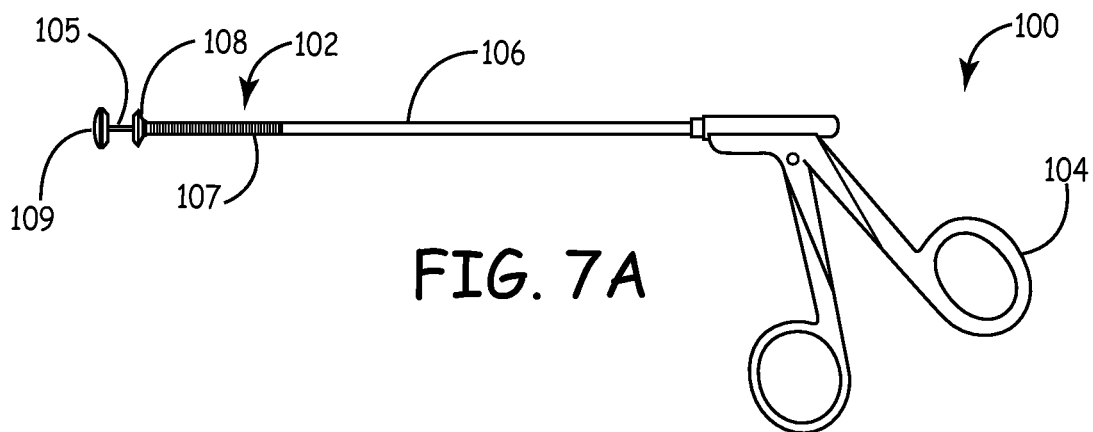


FIG. 5





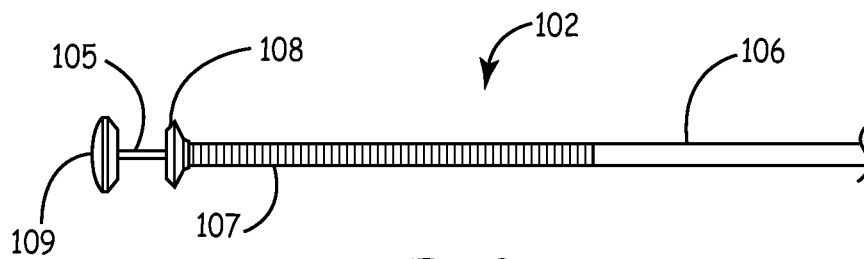


FIG. 8A

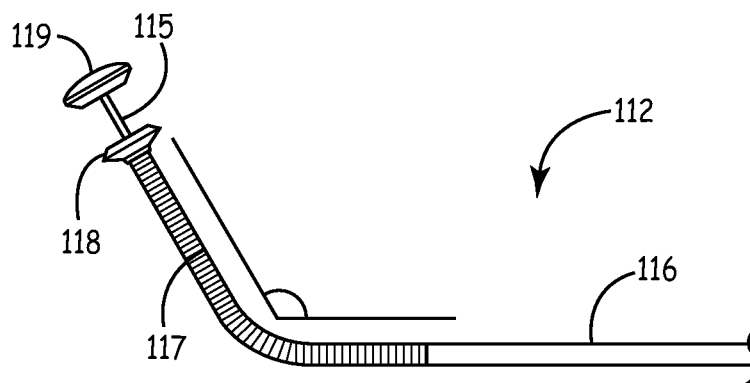


FIG. 8B

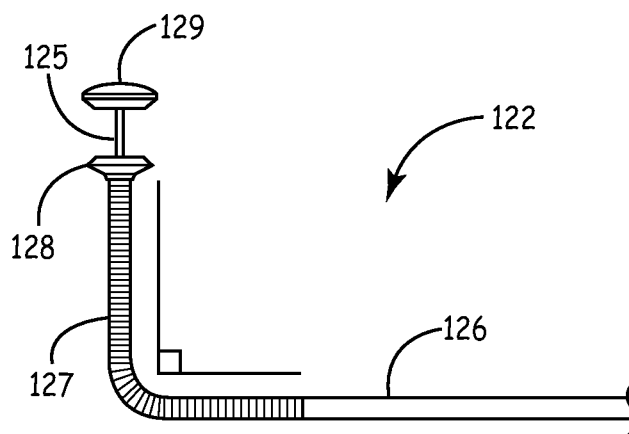


FIG. 8C

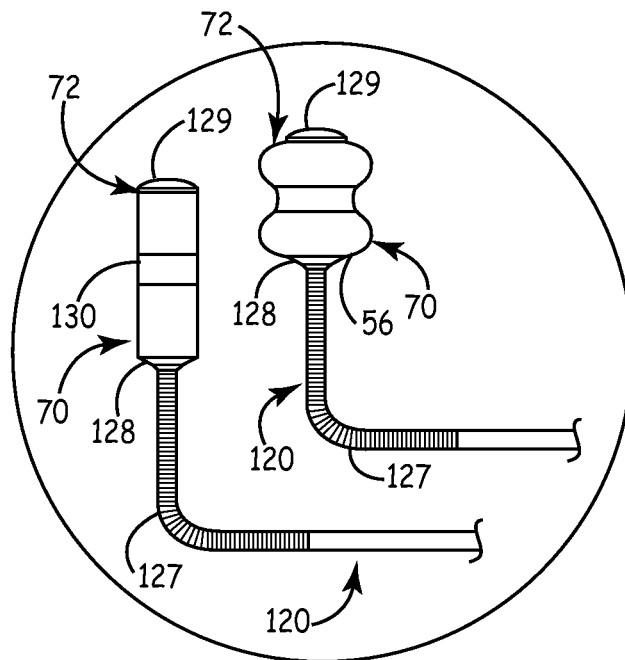


FIG. 9A

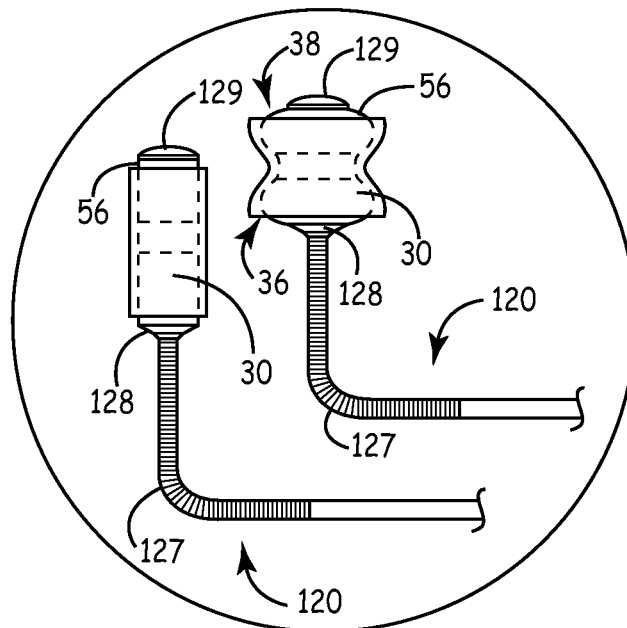


FIG. 9B

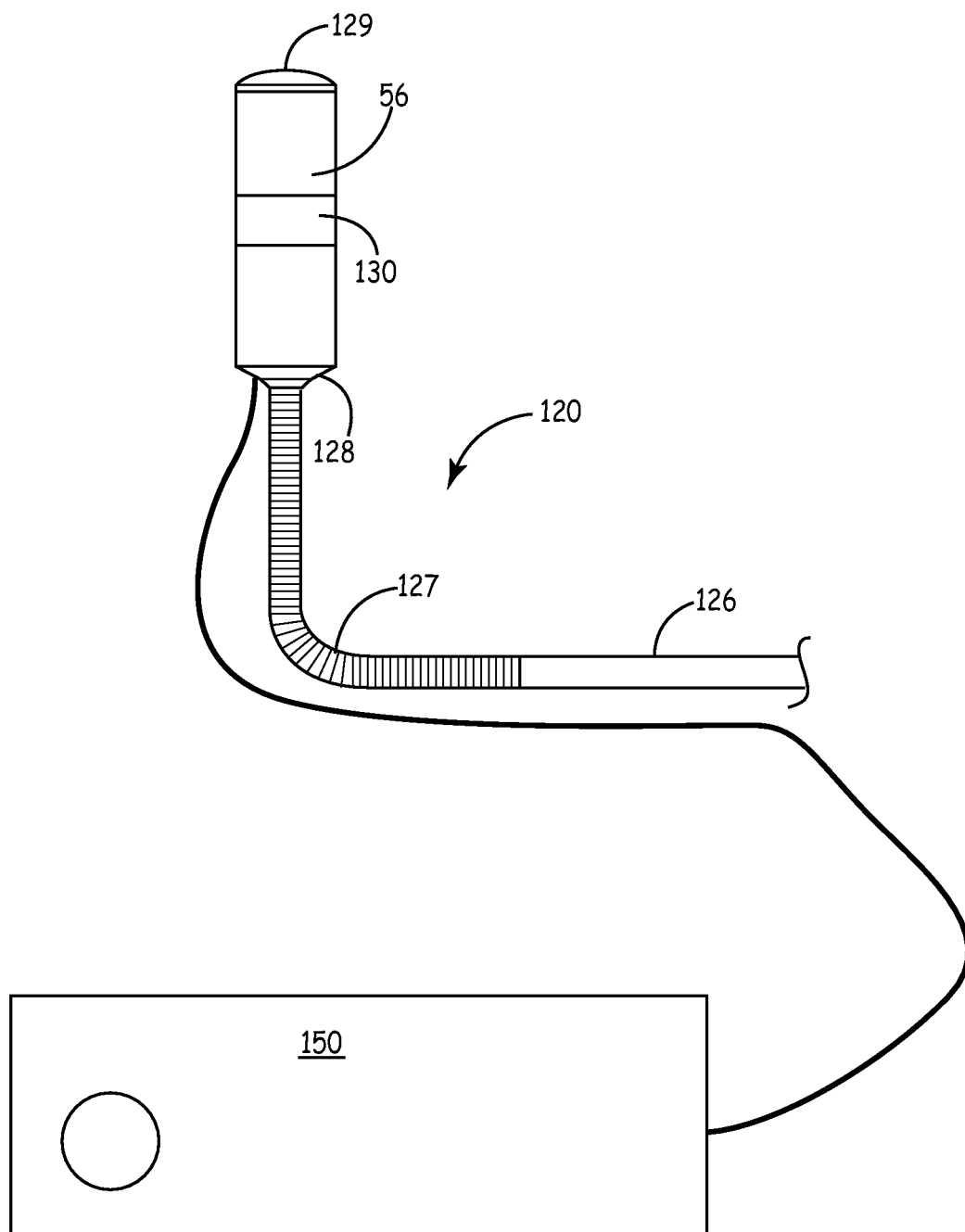


FIG. 10

1

## DEVICE FOR MAINTAINING PATENT PARANASAL SINUS OSTIA

### CROSS-REFERENCE TO RELATED APPLICATIONS

This application is a division of pending prior U.S. patent application Ser. No. 13/009,456, filed Jan. 19, 2011 by Edward J. Hepworth for DEVICE FOR MAINTAINING PATENT PARANASAL SINUS OSTIA, which in turn claims the benefit of U.S. patent application Ser. No. 12/181,416, filed Jul. 29, 2008, which is now U.S. Pat. No. 8,303,640 issued Nov. 6, 2012, by Edward J. Hepworth for DEVICE FOR MAINTAINING PATENT PARANASAL SINUS OSTIA, which in turn claims the benefit of Provisional Application Ser. No. 60/952,606, filed Jul. 30, 2007, and Provisional Application Ser. No. 61/050,827, filed May 6, 2008, each of which is hereby incorporated by reference in its entirety. Each of the above-identified patent applications is hereby incorporated herein by reference.

### FIELD OF THE INVENTION

The present invention relates to devices for treating acute and chronic inflammatory and infectious conditions of the nose and paranasal sinuses. In particular, the present invention relates to a biomedical device that is implantable into the nose, paranasal sinuses or sinus ostium.

### BACKGROUND

FIG. 1 illustrates a typical scenario that patients and physicians are faced with in the case of chronic sinus disease. A diseased maxillary sinus cavity **10** of patient **P** has become circumferentially swollen with thickening of the lining mucosa **11**. In a healthy maxillary sinus cavity **12**, mucosa **13** thinly lines the cavity. Maxillary sinus cavity **12** is located below orbit **14**, and frontal sinus **16** is located above orbit **14**. The sphenoid sinus is located in the high posterior nasal cavity. Sinus disease is often a result of allergic or inflammatory swelling in the nasal airway **18**, which frequently causes swelling in other nasal structures such as turbinates **20**. This not only causes obstruction of nasal airway **18**, but also the small openings, or ostia, which would normally allow for ventilation and drainage from sinus cavities **22**.

Conventional methods for treating chronic sinus disease have largely been directed to surgery by an otolaryngology (ENT) physician to correct the obstructive problems in the nose and paranasal sinuses. Treatment of sinus problems has assumed a top-five position in the ranking of expense in adult care in the United States in recent years. In many, if not most, instances, surgery has developed a reputation of futility since the number patients undergoing repeat surgical procedures is unacceptably high.

Recent advances toward minimizing sinus disease recurrence and optimizing surgical results have followed from the understanding that preservation of normal, healthy mucosa in the periphery of the surgical target site is paramount. This is particularly true in the area of the sinus ostia, where exposed bone or traumatized mucosa after sinus surgery has a robust ability to form circumferential and obstructive scar tissue which often completely closes off the sinus opening in as little as a few weeks. Combined experience with this problem has demonstrated that this obstructive process tends to occur within the first six weeks following surgery.

This timeframe for restenosis closely follows that of the now quite well understood inflammation process and the

2

timetable of early fibrosis formation in other regions in human tissue. Taking preservation of mucosa to the ultimate degree has recently led to the usage of balloon dilational devices in the nose for expanding the sinus ostia while leaving the lining mucosa intact. However, the use of sinoplasty with a balloon catheter is of relatively limited value since it does not maintain patent paranasal ostia when obstructive or inflammatory phenomena occur after surgery.

### SUMMARY

The present invention relates to a device for maintaining a patent paranasal sinus ostium. The device includes a tubular element having a first end proximal end, a distal end, and a center region between the proximal end and distal end. The tubular element has an insertion state and a deployment state. The tubular element is locatable in the sinus ostium when in the insertion state and expandable from the insertion state to the deployment state when located in the sinus ostium. In the deployment state, the center region confronts the sinus ostium with an outward radial force.

In other embodiments, the present invention relates to a device for delivering a stent. The device includes a handle with an actuation mechanism and a shaft having a proximal end and a distal end. The shaft proximal end is coupled to the handle. A wire extends through the shaft and has a proximal end and a distal end. The wire proximal end is operatively connected to the actuation mechanism. A first holding member is coupled to the shaft distal end and a second holding member is coupled to the wire distal end. An elastomeric member is coupled to the first holding member at a first end and to the second holding member at a second end. The stent is positionable around the elastomeric member such that actuation of the actuation mechanism in a first direction translates the second holding member toward to the first holding member to expand the elastomeric member. Actuation of the actuation mechanism in a second direction translates the second holding member away from the first holding member to contract the elastomeric member.

While multiple embodiments are disclosed, still other embodiments of the present invention will become apparent to those skilled in the art from the following detailed description, which shows and describes illustrative embodiments of the invention. Accordingly, the drawings and detailed description are to be regarded as illustrative in nature and not restrictive.

### BRIEF DESCRIPTION OF THE DRAWINGS

FIG. 1 is a partial cross-sectional view of a patient with chronic sinus disease, illustrating normal nasal and sinus cavities on the left side and diseased nasal and sinus cavities on the right side.

FIG. 2 is a plan view of a sinonasal stent device according to an embodiment of the present invention.

FIG. 3 is a partial cross-sectional view of a hollow directional sheath inserted into the nasal cavity for deployment of a stent device according to an embodiment of the present invention.

FIG. 4 is a partial cross-sectional view of the stent device expanding into position via a balloon having a waist at its center according to an embodiment of the present invention.

FIG. 5 illustrates a stent according to an embodiment of the present invention in position after placement between the sinus cavity and the nasal cavity.

FIG. 6A is a schematic view of the stent device illustrating a thickness of the stent material in an initial state before deployment.

FIG. 6B is a schematic view of the stent device illustrating a thickness of the stent material in a deployed stent device.

FIG. 7A is a plan view of an insertion device instrument coupled to a stent delivery portion having a straight tip configuration.

FIG. 7B is a plan view of an insertion device instrument coupled to a stent delivery portion having an obtusely angled tip configuration.

FIG. 7C is a plan view of an insertion device instrument coupled to a stent delivery portion having a substantially right angled tip configuration.

FIG. 8A is a plan view of a distal end of the stent delivery portion shown in FIG. 7A.

FIG. 8B is a plan view of a distal end of the stent delivery portion shown in FIG. 7B.

FIG. 8C is a plan view of a distal end of the stent delivery portion shown in FIG. 7C.

FIG. 9A is a plan view of an exemplary stent delivery portion according to an embodiment of the present invention in both contracted insertion and expanded deployment configurations without the thermally expansile stent in place.

FIG. 9B is a plan view of an exemplary stent delivery portion according to an embodiment of the present invention in both contracted insertion and expanded deployment configurations with the thermally expansile stent in place.

FIG. 10 is a schematic view of heating element control coupled to a stent delivery portion according to the present invention.

While the invention is amenable to various modifications and alternative forms, specific embodiments have been shown by way of example in the drawings and are described in detail below. The intention, however, is not to limit the invention to the particular embodiments described. On the contrary, the invention is intended to cover all modifications, equivalents, and alternatives falling within the scope of the invention as defined by the appended claims.

#### DESCRIPTION OF ILLUSTRATIVE EMBODIMENTS

FIG. 2 is a plan view of sinonasal stent 30 according to an embodiment of the present invention. Sinonasal stent 30 includes lumen 32 defined by inner wall 34 that passes through sinonasal stent 30 between ends 36 and 38. Sinonasal stent 30 also includes outer wall 40. Wall thickness  $t$  is the distance between inner wall 34 and outer wall 40. In some embodiments, sinonasal stent 30 has a tubular shape.

When deployed, sinonasal stent 30 has a substantially hourglass shape as shown including center or waist 42 having a smaller surface-to-surface diameter than ends 36 and 38. As will be described in more detail herein, the hourglass-like shape of the deployed stent functions in the self-positioning nature of the device, and waist 42 results from expansion of ends 36 and 38 around a short ostium in the sinus bony opening.

Prior to deployment, ends 36 and 38 may have a larger starting diameter than center or waist 42. Alternatively, the diameter of sinonasal stent 30 may be substantially uniform across waist 42 and ends 36 and 38, with deployment increasing the diameter of the ends 36 and 38 more than waist 42, resulting in a post-deployment hourglass shape. The pre-deployment shape of the device depends upon its ultimate composition, as some component materials have a higher void fraction and compressibility than others.

To produce sinonasal stent 30, biocompatible material may be formed into a cylindrical or alternative-shaped sleeve that, when deployed over an expanding balloon or other expansile deployment device, allows sinonasal stent 30 to generate an outward radial force within the area of interest. In contrast to conventional designs, sinonasal stent 30 is not of a size smaller than the ostium or cavity at the time of insertion. Rather, the shape of sinonasal stent 30, with waist 42 having a smaller diameter than ends 36 and 38, provides constant outward radial force, and thus expansile pressure to the sinus opening, that is not afforded by a cylinder of uniform diameter. This maintains the sinus ostia in a patent (i.e., open) position. Unlike a uniform-diameter tube of silicone rubber, the tapered, bi-conical shape of sinonasal stent 30 provides increased and durable outward pressure. In some embodiments, waist 42 is comprised of a material different than the material of the remainder of stent 30 (proximate ends 36 and 38) such that the material proximate ends 36 and 38 stretches the material of waist 42 in order to produce an outward radial force on the sinus ostium.

The materials and compositions used to form sinonasal stent 30 may preferably exhibit certain biochemical properties. For example, the sinonasal stent 30 may have intrinsic antimicrobial properties, such as those described in U.S. Pat. No. 4,603,152. Further, after conformation to the ostium, the material properties of sinonasal stent 30 maintain continued centrifugal pressure on the margins of the opening to discourage restenosis. The conformable, elastic properties of sinonasal stent 30 may be accompanied by a gradual biodegradation of the material of sinonasal stent 30 which obviates the need for removal. It may also allow the timed-release of impregnated compounds for constant exposure of the sinus and nasal tissue to selective bioactive pharmaceuticals. Indwelling durability may be variable, depending upon the disease process under treatment and as determined by the selectable material of sinonasal stent 30. Several exemplary materials may be of utility in sinonasal stent 30, as listed below in Table 1. The choice of materials is based upon demonstrated relative biointertness, retained elasticity after melting and annealing, and the possibility of porosity in the final state to allow the device to be a carrier for impregnated and releasable compounds.

TABLE 1

Primary Candidate Stent Compounds					
Compound	Young Modulus (MPa)	Melting Temp (C.)	Glass Temp (C.)	Porosity	Biologic $t^{1/2}$ (weeks)
Poly-ε-caprolactone	216	60	65	Variable	6-10
Polyhydroxybutyrate	70	55	-15	Variable	24-48
Poly-4-hydroxybutyrate	6	175	4	80%	24-48
Polyglycolic acid	1.5	230	Variable	Variable	8
Polyhydroxypropionate	1590	70	46.5	10%	Unknown
Polyhydroxyvalerate	570	77	-19	Variable	Variable

Polycaprolactone has been proposed as a material for a dissolvable ear tube apparatus in U.S. Pat. No. 4,650,488, and for a dissolvable epidural catheter in U.S. Pat. No. 5,129,889, and is one preferred material for sinonasal stent 30. In some embodiments, sinonasal stent 30 is comprised of a material that dissolves within about two to ten weeks. In other embodiments, sinonasal stent 30 is comprised of a material that dissolves within about one year. Several other materials may be considered for sinonasal stent 30 based upon their successful use in nasal, head, and neck surgical treatments and their

5

demonstrated relative biocompatibility. It should be noted that each of these materials, when combined with others or when placed into the proper matrix or void fraction, exhibits the desirable properties of a sinus stent: elasticity, controlled expandability, porosity for inclusion of elutable drugs, and adequate softness for withdrawal if needed from the nasal cavity without extensive tissue damage.

Other materials may be of preferential use in certain disease states where a longer indwelling time may be needed. Some example disease states that may require longer indwelling time include severe nasal polyposis or when chronic disease states such as cystic fibrosis or inverted papilloma, a type of intranasal neoplasm, are treated. Example materials suitable for longer indwelling time include, but are not limited to, polybutyrolactone, polyglycolic acid, hyaluronic acid in resin form, poly-4-hydroxybutyrate, crosslinked hyaluronic acid, porcine collagen in resin form, methylmethacrylate, cyanoacrylate, polybutylmethacrylate, poly(L-lactide) and poly(D-lactide), polybutylmethacrylate, and polyethylene covinyl acetate.

The biochemical properties of any of the above materials allow them to be partially melted by the use of a hot-water bath or solvent prior to insertion, which will then allow them to be expanded to conform to the sinus ostium or cavity without becoming brittle, fracturing, or otherwise disintegrating. Such conformational flexibility is preferred for sinonasal stent 30 to be inserted into the nasal or sinus passages.

Sinonasal stent 30 as described allows compounds such as anti-inflammatory, antibiotics, and other immune-modulating substances to be employed in a prolonged-contact manner in the sinus tissues. In some embodiments, materials incorporated into sinonasal stent 30 allow elution or slow release of therapeutic agents useful in treating chronic sinus disease. For example, sinonasal stent 30 may be configured to include a steroid or anti-inflammatory agent including, for example, dexamethasone, triamcinolone, prednisone, prednisolone, budesonide, mometasone, fluticasone, flunisolide, zafirlukast, montelukast, and/or zileuton. Sinonasal stent 30 may also be configured to include antineoplastics or fibroblast inhibitors, including, for example, mitomycin C, 5-fluorouracil, cyclosporine, methotrexate, and/or halofuginone. In addition, sinonasal stent 30 may be configured to include antiviral compounds including, for example, cidofovir and/or podophyllin. Sinonasal stent 30 may further be configured to include antibiotics including, for example, penicillins, cephalosporins, fluoroquinolones, macrolides, clindamycin, aminoglycosides, tetracycline, iodine/iodides, vancomycin, rifampin, and/or sulfa compounds. Furthermore, sinonasal stent 30 may be configured to include polyp-dehydrating medications including, for example, furosemide. Other anti-scar tissue compounds and mucolytics may also be included in sinonasal stent 30, including, for example, hyaluronic acid, various detergents and surfactants, and/or acetylcysteine. It should be noted that the therapeutic agents listed are merely exemplary, and any suitable pharmacological substance may be used in conjunction with sinonasal stent 30 to treat chronic sinus disease.

FIG. 3 illustrates a method and apparatus for deploying sinonasal stent 30 through the nasal cavity. In the embodiment shown, hollow directional sheath 50 is inserted into the nasal cavity using endoscopic guidance. Wire 52 is passed through sheath 50 and into maxillary sinus cavity 12 which is found lateral to middle turbinate 20 on the lateral nasal wall. This procedure may also be utilized for frontal and sphenoid sinus disease. Insertion of wire 52 is followed by passage of catheter 54. Expansile balloon or elastomeric member 56 is disposed around catheter 54 and is positioned to span sinus

6

ostium 58 in preparation for placement of sinonasal stent 30 at the bony opening into sinus 60. This may be viewed by endoscopic examination of the nasal cavity and sinuses.

FIG. 4 provides further detail of guidewire 52, catheter 54, balloon 56, and sinonasal stent 30. As shown, sinonasal stent 30, which has waist 42 at its center, undergoes expansion by balloon 56 during deployment. In the embodiment shown, sinonasal stent 30, guidewire 52, catheter 54, and balloon 56 are positioned with the assistance of positioning directional sheath 50. In other embodiments, sheath 50 and wire 52 are not used to deploy the device, particularly in the case of a previously performed aggressive surgical opening of sinus 60. Sinonasal stent 30 is depicted during the process of inflation to form a self-retaining, self-positioned opening support for sinus mucosa 62 and bone of sinus ostium 58 as they heal to allow communication between sinus cavity 12 and nasal cavity 65.

Balloon 56 used in deployment of sinonasal stent 30 is an isobaric, compliant, expansion balloon. That is, as more air or fluid is delivered to balloon 56, its size increases rather than its internal pressure. This will allow the proximal segment 70 and distal segment 72 of balloon 56 to expand to dilate sinonasal stent 30 to as large a diameter as the surgeon desires, based upon the topography of the diseased sinus 60. The expanding balloon 56 will push the sinonasal stent 30 into conformity with any surface irregularities of the anatomy, resolving shortcomings of conventional cylindrical stents. A tight band, or waist, in the balloon 56 at its midlength assists in forming the hourglass shape of sinonasal stent 30, providing a means for self-positioning of balloon 56 and sinonasal stent 30. Difficult-to-reach regions of sinus 60 may be accessed with the assistance of a curved directional sheath 50 to provide angulation of catheter 54 in the direction of the target tissue, as shown in FIG. 4.

The possible adherence of sinonasal stent 30 to balloon 56 after deployment, with subsequent tearing or deformation of sinonasal stent 30 after deployment, has been investigated. A possible solution was proposed in U.S. Pat. No. 5,746,745 (incorporated herein by reference) by surface alterations in balloon 56. Surface coatings have also been proposed to release sinonasal stent 30 from balloon 56. However, the properties of the materials discussed above for sinonasal stent 30 may eliminate the need for a separation process based upon the shrinkage that may occur during cooling/hardening.

FIG. 5 shows the sinonasal stent 30 in position after placement and removal of guidewire 52, catheter 54, and balloon 56. When deployed, sinonasal stent 30 provides a constant expansile pressure against mucosa 62 and bone 74 of the sinus opening with clear communication with nasal cavity 65. In addition, adjacent sinus anatomy 76 remains normal, intact, and unimpeded from its function by sinonasal stent 30.

FIG. 6A is a schematic view of sinonasal stent 30 in an initial state before deployment, and FIG. 6B is a schematic view of sinonasal stent 30 after deployment. Both FIGS. 6A and 6B illustrate side and axial views of sinonasal stent 30. The schematics of FIGS. 6A and 6B are provided to illustrate the thickness of the stent material before and after deployment, but do not necessarily illustrate the actual shape of sinonasal stent 30 in these states. As shown in FIG. 6A, prior to deployment, sinonasal stent 30 has material thickness  $t_1$ , inner diameter  $i_{in1}$ , and outer diameter  $i_{out1}$ . As shown in FIG. 6B, after deployment sinonasal stent 30 has material thickness  $t_2$ , inner diameter  $i_{in2}$ , and outer diameter  $i_{out2}$ .

Prior to deployment (FIG. 6A), material thickness  $t_1$  of sinonasal stent 30 is sufficient to allow integrity of outer stent wall 38 to be maintained after full expansion and deployment. In addition, initial wall thickness  $t_1$  is such that, when

expanded, deployed wall thickness  $t_2$  is sufficient to allow sinus drainage through lumen **32** while maintaining adequate structural integrity for stenting purposes. Initial wall thickness  $t_1$  of sinonasal stent **30** may also be determined by, for example, the minimum post-expansion wall thickness  $t_2$  needed to maintain outward expansion, the compressibility of the material of sinonasal stent **30**, and the minimum inner diameter  $i_{in1}$  needed to accommodate a deployment device.

After deployment (FIG. 6B), the selected materials for sinonasal stent **30** retain the properties of an elastomer to provide outward radial pressure on the ostium during early healing. It is important to note that the chosen materials each have the capability of assuming an essentially liquid state at acceptable above-body-temperature so as to avoid not only extensive thermal injury to the patient during deployment, but also to avoid elastic effect during expansion and insertion of sinonasal stent **30**. Elasticity during expansion would have the undesirable effect of stent shrinkage after deployment.

In some embodiments, the minimum deployed diameter  $i_{out2}$  of sinonasal stent **30** is approximately 6 mm, based upon surgical experience. To maintain the integrity of inner wall **34** and outer wall **40**, deployed wall thickness  $t_2$  of minimum 1 mm may be used. Current deployment balloons have an outer undeployed diameter of approximately 2 mm. To achieve a final outer diameter  $i_{out2}$  of 6 mm and a serviceable inner diameter  $i_{in2}$  of 4 mm for drainage and viewing of the sinus cavities beyond sinonasal stent **30** with a typical endoscope, a pre-deployment stent wall thickness  $t_1$  of at least 1.5 mm may be used.

While delivery of sinonasal stent **30** has been described with regard to use of guidewire **52**, catheter **54**, and balloon **56**, other tools or devices may be used to deliver sinonasal stent **30**. For example, FIGS. 7A, 7B, and 7C illustrate devices that may be used to position, insert, and deploy the sinonasal stent **30**, according to embodiments of the present invention. In particular, FIG. 7A is a plan view of insertion device **100** coupled to stent delivery portion **102** having a straight distal end, FIG. 7B is a plan view of insertion device instrument **110** coupled to stent delivery portion **112** having an obtusely angled distal end, and FIG. 7C is a plan view of insertion device instrument **120** coupled to stent delivery portion **122** having a substantially right angled distal end. FIG. 8A is a plan view of the straight distal end of stent delivery portion **102**, FIG. 8B is a plan view of obtusely angled distal end of stent delivery portion **112**, and FIG. 8C is a plan view of substantially right angled distal end of stent delivery portion **122**. While the following discussion is directed to the components and functionality of insertion device **100**, the components and functionality of insertion devices **110** and **120** are substantially similar, unless otherwise noted. In addition, similar features to those described with regard to insertion device **100** are similarly numbered for insertion devices **110** and **120**.

Insertion device **100** includes forceps-like handle **104** which, when actuated, slides wire **105** within shaft **106**. In some embodiments, shaft **106** has a length of about six inches (152.4 mm). At the end of the straight portion of shaft **106**, a welded stainless steel hollow spring **107** with a memory shape may be coupled, according to embodiments of the present invention. Spring **107** is straight and springs **117** and **127** are angled to facilitate access to various parts of the sinus. That is, spring **107** has a straight configuration, which is suitable for positioning of sinonasal stent **30** into the sphenoid sinus, for example. Spring **117** has an obtusely angled configuration (e.g., 120°), which is suitable for positioning of sinonasal stent **30** into the frontal sinus, for example. Spring **127** has a substantially right angled configuration, which is

suitable for positioning of sinonasal stent **30** into the maxillary sinus ostium, for example. Springs **107**, **117**, and **127** allow malleability and flexibility of the tip of instruments **100**, **110**, and **120**, respectively, to accommodate variation in anatomy from one patient to another. According to some embodiments of the present invention, springs **107**, **117**, and **127** are shapeable by the surgeon to customize the spring for sinus access in the anatomy of a particular patient.

According to some embodiments of the present invention, moving forceps-like handles **104** of the instrument **100** open and closed moves wire **105** within shaft **106**. Lower lip **108** may be formed or attached to spring **107** and/or shaft **106**, and upper lip **109** may be formed or attached to wire **105**. Moving the forceps-like handles **104** of the instrument **100** open and closed thus moves upper lip **109** towards and away from lower lip **108**, respectively, according to embodiments of the present invention.

To illustrate methods for using of insertion devices **100**, **110**, and **120**, FIG. 9A is a plan view of an insertion device **120** as shown in FIGS. 7B and 8B with balloon **56** in both contracted and expanded configurations. While the following discussion focuses on the use of insertion device **120**, it will be appreciated that the principles described are also applicable to insertion devices **100** and **110**.

As shown in FIG. 9A, balloon **56** may be held, clipped, or otherwise secured between the upper lip **129** and the lower lip **128**. Sleeve **130** may be placed over the balloon **56** and either adhered and/or pressure fit and/or otherwise secured in place over a middle section of balloon **56**. In some embodiments, balloon **56** extends between upper lip **129** and lower lip **128** in a substantially cylindrical configuration. The substantially cylindrical configuration of balloon **56** may have a diameter similar to the inner diameter of the sleeve **130**, as shown by the contracted configuration of insertion device **120** in FIG. 9A.

When the distance between upper lip **129** and lower lip **128** is reduced, such as, for example, by either squeezing together or separating handles **124** of instrument **120**, balloon **56** expands in diameter as shown in contracted configuration of insertion device **120** in FIG. 9A. Sleeve **130** may be made of a material which is less elastic than the material of balloon **56**, such that a middle section of the balloon **56** is restricted from expanding to the same diameter as the ends **70** and **72** of the balloon **56**, which gives the balloon **56** a substantially hourglass-shaped configuration. In some embodiments, sleeve **130** is integral with balloon **56**.

FIG. 9B is a plan view of insertion device **120** with thermally expansile sinonasal stent **30** disposed over balloon **56** in both contracted and expanded configurations. As described above, sinonasal stent **30** may be deformable, elastic, and/or heat activated to conform sinonasal stent **30** to the shape of balloon **56**, in order to impart sinonasal stent **30** with a substantially hourglass-shaped configuration. FIG. 9B illustrates sinonasal stent **30** and underlying balloon **56** in an insertion (i.e., contracted) position and also in a deployment (i.e., expanded) position, according to embodiments of the present invention.

Thus, according to some embodiments of the present invention, insertion devices **100**, **110**, or **120** may be used to place and insert sinonasal stent **30** into the appropriate position, for example in the sinus, while sinonasal stent **30** and balloon **56** are in the contracted position. Insertion devices **100**, **110**, or **120** may then be used to expand balloon **56** to conform sinonasal stent **30** to the proper size and shape, and/or to otherwise conform sinonasal stent **30** to the geometry of surrounding tissue, as depicted in FIGS. 3 and 4. Once sinonasal stent **30** has been placed and expanded and/or

shaped, balloon **56** may be returned to the contracted insertion position while leaving sinonasal stent **30** in place, and insertion device **100**, **110**, or **120** and balloon **56** may be withdrawn.

In some embodiments, balloon **56** has an outer diameter of approximately 4 mm and the distance between upper lip **129** and lower lip **128** is approximately 12 mm in the contracted insertion position. In some embodiments, balloon **56** has an outer diameter at ends **70** and **72** of approximately 8 mm and the distance between the upper lip **129** and lower lip **128** is approximately 8 mm in the expanded deployed position. Sinonasal stent **30** after deployment may have an outer diameter of approximately eight millimeters toward ends **36** and **38**, and approximately 6 mm in the middle, corresponding to the inner diameter of the sinus ostium, according to embodiments of the present invention. As discussed above, balloon **56** may be comprised of an expansile elastomer. These insertion procedures may be viewed by endoscopic examination of the nasal cavity and sinuses.

In some embodiments, lower lip **128** may be a collet, for example a 4 mm diameter metallic disc. Balloon **56** may be an elastomer cylinder with a minimal inner diameter of just slightly larger than shaft **126**, such as, for example, approximately 1.5 millimeters. According to some embodiments of the present invention, shaft **126** passes through balloon **56** and is welded into upper lip **129**. Upper lip **129** may be, for example, another disc. When handles **124** are actuated, balloon **56** is compressed in length and widened in diameter and circumference to expand sinonasal stent **30** into position, according to embodiments of the present invention.

FIG. **10** is a schematic view of heating element control **150** coupled to stent delivery portion **122** of insertion device **120**, according to the present invention. FIG. **10** illustrates insertion device **120** in one configuration that allows monopolar electric current to be passed through insertion device **120**. Heating element **152** may be inserted balloon **56** as shown, and/or may be incorporated within shaft **126**, according to embodiments of the present invention. If wire **125** that runs through balloon **56** is a resistive element, current applied to insertion device **120** by heating element control **150** through heating element **152** can be utilized to warm the elastomer of balloon **56** to avail the use of thermal plastic properties of the material of sinonasal stent **30**. This can allow in-situ melting and cooling of sinonasal stent **30** at sinus ostium **58**, a specific advantage in solving the problem of constant outward radial force from sinonasal stent **30** applied to counteract the constant centripetal force of scar tissue formation in the healing of sinus ostium **58**, according to embodiments of the present invention.

According to some embodiments of the present invention, balloon **56** is of a bimaterial nature. That is, the inner part of balloon **56** may be made with a stronger, non-melting material and the outer part of balloon **56** may be made with a different material having a lower durometer and being more pliable.

## EXAMPLES

The following Examples are included to demonstrate preferred embodiments of the invention. It should be appreciated by those of skill in the art that the techniques disclosed in the Examples which follow represent techniques discovered to function well in the practice of the invention, and thus can be considered to constitute preferred modes for its practice. However, those of skill in the art should, in light of the present disclosure, appreciate that many changes can be made in the

specific embodiments which are disclosed and still obtain a like or similar result without departing from the spirit and scope of the invention.

Sinonasal stent **30** is of use both intraoperatively after surgical opening of a sinus cavity and postoperatively in a clinic setting. Office use of the device may eventually predominate, since most surgical procedures, particularly those done in the primary setting, are assumed by the operating surgeon to be intrinsically successful. Early postoperative failures (within 6 weeks) are common, however, and slow postoperative progression of disease happens frequently.

### Example 1

For formation of sinonasal stent **30**, the materials noted above for longer indwelling time may be of preferential use in certain disease states—for instance in the case of severe nasal polyposis or when chronic disease states such as cystic fibrosis or inverted papilloma, a type of intranasal neoplasm, are treated. Sinonasal stent **30** as described above and illustrated in FIGS. **2-5** is prepared for insertion into a sinus ostium.

Surgery to expose and open a complicated and/or tortuous frontal sinus opening often results in a lengthy segment of denuded bone. This may occur either from presurgical disease causing weakening of the mucosal lining in the region or may be required by the extent of surgery necessary to find and create an opening. The surgeon expects that normal wound healing processes in the sinus and nose will eventually likely lead to at least partial closure of this opening. Sinonasal stent **30** is placed into the sinus opening to prevent later revision surgery or extensive reworking of the area in the office at follow-up. The stent is then removed after a few weeks, generally when the patient complains of fullness or discomfort in the area. Alternatively, a gradual, planned period of degradation of the stent occurs in situ, eliminating the need to remove the implanted stent.

In other alternatives, sinonasal stent **30** is impregnated with one or more of the therapeutic agents listed above to facilitate the healing process and further inhibit closure of the ostial opening.

### Example 2

Many sinus surgeons conduct interval examination of patients with chronic inflammatory disease in the nose. These patients may or may not have had previous surgery. Endoscopic examination of the nose reveals a purulent drainage from a particular sinus or a similar disease process such as an isolated polyp obstructing a sinus. The introducing technique depicted in FIG. **3** can be used to identify the opening into the sinus. The opening may be widened to a functional caliber either by means of conventionally used punches or with the expansion of balloon **56** and sinonasal stent **30** across its ostium. Sinonasal stent **30** may later degrade or be withdrawn, obviating the need for major surgical procedure. Sinonasal stent **30** is composed of the same material as that in Example 1—a device with a usable life of approximately 6 weeks.

### Example 3

Many patients suffer from aggressive pansinus polyposis due to, for example, asthma-like conditions in their nasal tissues, aspirin-sensitivity disorders, or other similar conditions. These patients have a much more futile problem in many respects than those in Examples 1 and 2. They are often expected to have recurrence of their disease and become the



11

subject of multiple, serial surgical procedures. Without the constant application of pharmaceuticals, generally in the form of surfactants, high potency steroids, or diuretic solutions, the polyps reform. Similar problems are encountered with the disease state of inverted papilloma which has a high tendency of recurrence and a risk of malignant transformation. These disease states would better be treated with pansinus stenting preemptively at the time of surgery with as long a dissolution time in stent wall **40** as allowable for elution of a drug. This would favor the use of any of the stent material compounds listed in Table 1 or the materials suitable for longer indwelling time listed above.

In summary, the present invention relates to methods, compositions and apparatuses for treating chronic and/or recurring acute inflammatory and infectious conditions of the nose and paranasal sinuses. Certain embodiments may concern a stent device that is implantable into the nose, paranasal sinuses or sinus ostia. In some embodiments, the stent is made from material of a customizable shape, which may be biocompatible, dissolvable, retrievable, and/or drug-elution capable or some combination thereof. The stent may dissolve over a predetermined and variable schedule, may be impregnated with one or more selected therapeutic compounds, and may be easily removed at the discretion of the treating physician.

In various embodiments, the stent comprises a material that is formed prior to insertion by partial melting with heat or chemical alteration. In some embodiments, the chemical composition of the material allows the melting to be repeated to allow for nondestructive removal of the device. Such heat deformable materials are well known in the art and any such known material may be used. Alternatively, the stent may comprise a coated metal or polymer that exhibits a "memory" characteristic, such that the size and shape of the stent may be manipulated between alternative conformations for ease of insertion and/or removal.

Other embodiments may concern catheters of use for inserting the stent device into a selected sinus location. In some embodiments, such catheters may comprise a guidewire and a hollow directional sheath for localizing and directing the deployment of the device into a selected sinus location.

Still other embodiments may concern methods of treating a patient with a sinus disease, comprising obtaining a stent device as discussed herein and inserting the device into the nose, the paranasal sinuses or the sinus ostia of the patient. The insertion may occur after sinus surgery, to prevent or reduce sinus closure after surgery. Alternatively, the device may be inserted as an alternative to surgery in cases where nasal or sinus closure is not sufficient to require surgical intervention. Preferably, non-surgical intervention with a stent device as described herein may prevent the progression of sinus disease to a point where surgery is required, allowing for non-surgical treatment and/or cure of the sinus condition. The use of stent devices comprising one or more therapeutic agents further contributes to treatment.

The sinonasal stent of the present invention exhibits significant advantages over previously known methods and devices. The described device is conformable to the irregular geometry of the nasal and sinus passages, exhibits sufficient outward pressure to counteract fibroblast contraction, may comprise a variety of therapeutic agents for sustained release to treat or prevent inflammation, infection and/or scarring, may comprise a self-centering geometry to maintain the position of the device in the sinus ostia, is designed for ease of insertion and/or removal, and may alternatively be comprised of a material that dissolves in situ in the sinus, obviating the need for removal of the inserted stent device. The claimed

12

device provides a stent design that is employable under direct endoscopic guidance owing to a small insertion diameter. Once delivered to the sinus to be treated, the stent can be expanded by balloon inflation or other methods to conform directly to the topography of the ostium.

Various modifications and additions can be made to the exemplary embodiments discussed without departing from the scope of the present invention. For example, while the embodiments described above refer to particular features, the scope of this invention also includes embodiments having different combinations of features and embodiments that do not include all of the described features. Accordingly, the scope of the present invention is intended to embrace all such alternatives, modifications, and variations as fall within the scope of the claims, together with all equivalents thereof.

What is claimed is:

1. A method for maintaining a patent paranasal sinus ostium, the method comprising:
  - delivering a tubular element in an insertion state to the sinus ostium, wherein the tubular element includes a proximal end, a distal end, and a center region between the proximal end and distal end; and
  - expanding the tubular element from the insertion state to a deployment state when located in the sinus ostium by partially melting the tubular element to allow reshaping of the tubular element from the insertion state to the deployment state, wherein, in the deployment state, the center region confronts the sinus ostium with an outward radial force.
2. The method of claim 1, wherein the delivering step comprises:
  - inserting a directional sheath into a nasal cavity;
  - inserting a guidewire through the directional sheath and into a sinus cavity via the sinus ostium;
  - inserting a catheter through the directional sheath over the guidewire, wherein the catheter includes a balloon that is disposed within a lumen of the tubular element; and
  - positioning the tubular element in the sinus ostium.
3. The method of claim 2, wherein the expanding step comprises:
  - inflating the balloon to expand the tubular element from the insertion state to the deployment state.
4. The method of claim 1, wherein the delivering step comprises:
  - positioning the tubular element around an elastomeric member connected to first and second holding members of an insertion device; and
  - positioning the tubular element in the sinus ostium with the insertion device.
5. The method of claim 4, wherein the expanding step comprises:
  - actuating the insertion device in a first direction to translate the second holding member toward the first holding member to expand the elastomeric member.
6. The method of claim 5, and further comprising:
  - actuating the insertion device in a second direction to translate the second holding member away from the first holding member to contract the elastomeric member to facilitate release of the tubular element from the insertion device.
7. The method of claim 1, wherein the expanding step comprises:
  - expanding the tubular element such that the center region has a radius that is less than a radius of at least one of the proximal end and the distal end.
8. The method of claim 1, wherein the partially melting step further comprises:

**13**

cooling of the tubular element in-situ at the sinus ostium so as to allow the tubular element to provide the outward radial force from the tubular element to counteract a constant centripetal force of scar tissue formation during healing of the sinus ostium.

**9.** A method for maintaining a patent paranasal sinus ostium, the method comprising:

delivering a tubular element in an insertion state to the sinus ostium, wherein the tubular element includes a proximal end, a distal end, and a center region between the proximal end and distal end;

expanding the tubular element from the insertion state to a deployment state when located in the sinus ostium by partially melting the tubular element to allow reshaping of the tubular element from the insertion state to the deployment state; and

providing a constant outward radial force from the tubular element to the sinus ostium, wherein, in the deployment state, the center region is configured to confront the sinus ostium with the constant outward radial force to counteract a constant centripetal force of scar tissue formation during healing of the sinus ostium.

**10.** The method of claim 9, wherein the expanding step further comprises:

leaving the tubular element in place in conformation to a given geometry of surrounding tissue of the sinus ostium.

**14**

**11.** A method for maintaining a patent paranasal sinus ostium, the method comprising:

delivering a tubular element in an insertion state to the sinus ostium, wherein the tubular element includes a proximal end, a distal end, and a center region between the proximal end and distal end; and

expanding the tubular element from the insertion state to a deployment state when located in the sinus ostium, wherein, in the deployment state, the center region confronts the sinus ostium with an outward radial force;

wherein the delivering step comprises:

positioning the tubular element around an elastomeric member connected to first and second holding members of an insertion device; and

positioning the tubular element in the sinus ostium with the insertion device;

wherein the expanding step comprises:

actuating the insertion device in a first direction to translate the second holding member toward the first holding member to expand the elastomeric member.

**12.** The method of claim 11, and further comprising:

actuating the insertion device in a second direction to translate the second holding member away from the first holding member to contract the elastomeric member to facilitate release the tubular element from the insertion device.

\* \* \* \* \*